

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>295079</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/30/2007</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAINVIEW HEALTH &amp; REHAB</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 KOONTZ LANE</b> <b>CARSON CITY, NV 89701</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 13812 This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 8/28/07 through 8/30/07.</p> <p>Complaint #NV00015654 was a self-reported incident which alleged that a resident physically and verbally abused two other residents. The complaint was substantiated with no regulatory deficiencies cited.</p> <p>Complaint #NV00015624 was a complaint that alleged the facility was admitting residents with mental health issues to their locked unit which put the frail demented elderly in jeopardy. The complaint was unsubstantiated.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.